Rushcliffe Care Limited

Castle Donington Nursing Home

Inspection report

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Date of inspection visit: 28 July 2014
Date of publication: 05/01/2015

Ratings

Overall rating for this service	Requires Improvement
Is the service safe?	Requires Improvement
Is the service effective?	Requires Improvement
Is the service caring?	Good
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Overall summary

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, and to provide a rating for the service under the Care Act 2014.

The inspection was unannounced on 28 July 2014. This meant the provider and staff did not know we were coming. At the last inspection on 23 May 2013 the provider was compliant with the regulations we assessed.

Castle Donington Nursing Home provides accommodation and nursing care for up to 60 people

Summary of findings

with nursing needs, including needs associated with age and dementia. The service is divided into four units. On the day of our inspection there were 57 people living at the home.

Castle Donington Nursing Home is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service and has the legal responsibility for meeting the requirements of the law; as does the provider. At the time of our inspection an acting manager was employed at the service. They had applied to become the registered manager and the application was being processed.

CQC is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLs) and to report on what we find. The provisions of the MCA are used to protect people who might not be able to make informed decisions on their own about the care or treatment they received. We found that the provider had adhered to the DoLS legislation. Some people's care records lacked the correct documentation to show their capacity to consent to care and treatment had been appropriately assessed, and formal best interest decisions made.

Whilst staff were deployed across the service where required, this affected the consistency and continuity of care.

We found some concerns with the administration of medicines. Nursing staff did not always ensure people had taken their medication safely. Satellite kitchens that were used to serve food and make snacks and drinks were found to be unclean.

People's needs were assessed and plans of care and risk assessments developed so staff knew how to meet them. However, information about people's preferences, routines and social history was limited. This meant people may not always have received care and treatment that was personalised.

We found that people's needs were not always recorded accurately. We also found concerns that people's needs had not always been effectively managed when changes had occurred. We found examples that showed due to inadequate record keeping, action taken to refer to health professionals was not as timely as is should have been. Also, it was difficult to ascertain that people's needs were met all the time and in accordance to their assessed needs.

People using the service and relatives told us they found staff to be caring, kind and supportive. We observed that staff showed dignity and respect when supporting people.

People received opportunities to participate in social activities, interests and hobbies. Support was also provided that enabled people to have their religious and spiritual needs met by visiting ministers.

Staff received appropriate training to meet the needs of people they cared for. The provider had systems in place to check and monitor the quality and safety of service. However, we found some concerns with the checks in place for monitoring care records.

We found a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of this report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was not consistently safe.

Staffing levels and the deployment of staff did not always provide people with consistent support.

People could not be assured they always received their medication safely.

The Mental Capacity Act (MCA) legislation had not been fully adhered to. Where people lacked capacity to consent to care and treatment, MCA assessments and best interest decisions were not always recorded.

Requires Improvement

Is the service effective?
The service was not consistently effective.

People's health and well-being was not always monitored and recorded accurately. Changes to people's needs was not always acted upon in a timely manner.

People's dietary and nutritional needs were met.

Staff received appropriate training and support to enable them to meet the needs of people they cared for.

Requires Improvement

Is the service caring?
The service was caring.

We observed staff were kind and caring.

Information was available for people about the service, including independent advocacy services.

People and relatives we spoke were positive about the staff and said they treated people with dignity and respect.

Good

Is the service responsive?
The service was not consistently responsive.

People's preferences, routines and what was important to them was not always recorded.

Social activities, interest and hobbies were provided but staff did not always support people to participate.

People and relatives told us they had been involved in the development and review of assessments and plans of care.

Requires Improvement

Is the service well-led?
The service was not consistently well-led.

Requires Improvement

Summary of findings

The acting manager was working on driving improvements forward and recognised this was an on-going process.

The provider had checks in place that monitored the safety and quality of the service but these had not always identified concerns, and improvements required.

Castle Donington Nursing Home

Detailed findings

Background to this inspection

This report was written during the testing phase of our new approach to regulating adult social care services. After this testing phase, inspection of consent to care and treatment, restraint, and practice under the Mental Capacity Act 2005 (MCA) was moved from the key question 'Is the service safe?' to 'Is the service effective?'

The ratings for this location were awarded in October 2014. They can be directly compared with any other service we have rated since then, including in relation to consent, restraint, and the MCA under the 'Effective' section. Our written findings in relation to these topics, however, can be read in the 'Is the service safe' sections of this report.

This inspection was completed by an inspector, a specialist advisor in nursing care and an Expert by Experience, this was a person who had personal experience in caring for an older relative.

The inspection was unannounced on 28 July 2014.

Before our visit we looked at and reviewed the provider's information return. This is information we asked the provider to send us about how they are meeting the requirements of the five key questions. We reviewed historical data that we had received from the provider. This included information the provider had a duty to notify us of. We also contacted Leicestershire County Council and the locality Clinical Commissioning Group (CCG) for feedback. These organisations had funding responsibility for people who were using the service. We also contacted some health and social care professionals who visited the service.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. We completed two SOFI observations on six people who used the service.

We spoke with three people who used the service and five visiting relatives for their views about the service. We spoke with a senior manager who was present on the day of the inspection and had responsibility for the home above the home manager. We also spoke with two nurses, six care staff, two care team leaders, two domestic staff and two kitchen staff. The acting manager was not present on the day of our inspection but we spoke with them afterwards. We looked at the care records of four people who used the service and other documentation about how the home was managed. This included policies and procedures, records of staff training and records associated quality assurance processes.

Requires Improvement

Is the service safe?

Our findings

Relatives told us that whilst they thought their relative was safe they did have concerns about the staffing levels. A relative told us, "There's not always staff around but on the whole I feel [name] safe and has their needs met." Another relative made a similar comment, "Staff know my relative so well, you can't fault them but I don't think there's enough staff." Additional comments included, "The staff are very busy especially at meal times."

Our observations in one of the units found examples where out of three care staff on duty, two care staff had breaks that overlapped. This meant that a single member of staff was on their own for 15 minutes. Whilst we saw that care staff checked if people required assistance with personal care needs before their break, some people required the assistance of two staff. This meant that there could have been a delay in peoples' needs being met. We also observed there were periods on all four units where staff were not present. We saw that care staff had attached a call bell to a person's clothing to enable them to call for assistance if required. This person had capacity to do this. However, most people relied on staff to be within sight to respond to their care support needs.

We observed a machine that was used to feed a person who could not have food by mouth started alarming to indicate the feed had finished. We noted it took 22 minutes for the nurse to respond. The machine bleeped continually during this time. Whilst this was not detrimental to the person's health the sound of the bleeping may have been irritating to the person and others.

The nurse in charge told us and care staff confirmed, that one 'floating' staff was rostered to work upstairs and downstairs. This was a member of staff that worked across units where support was required. However, they said this did not happen often due to staff covering for sickness and vacancies. Comments received from staff included, "We should have a floater but rarely do. We have people that require two staff to support, some people have behaviours that are challenging." Another care staff member worker said, "Staffing levels are okay people are safe but it could be better. Quite often people have to wait to have the call bell responded to and assistance provided with toileting."

We spoke with the senior manager about the comments made about staffing levels and our observations. We also spoke with the acting manager after our inspection. They told us that they were in the process of recruiting more care staff to fully complement the staff team. They also said that the 'floating' care staff would be changed to a permanent staff member on the unit with the greatest needs. Current staff vacancies were managed either by an agency that provided nursing staff and bank staff or existing staff covered additional shifts where possible. Bank staff are employed by the service but are only used as and when required.

Care staff told us that they had designated units that they worked on but they were asked to work in other areas of the home as and when required. We asked care staff about people's individual needs but found some staff were unsure as they did not usually work on the unit they were working on. We asked care staff if they had opportunities to read people's care plans and risk assessments. Care staff told us they received limited opportunities due to time, and relied on information shared by the nurse in charge. This meant people could not be assured that care staff were fully aware of all their needs and preferred ways of support that kept them safe.

We looked at some personal fire evacuation plans and found they lacked detailed information of what support people required in an emergency situation to remain safe. This was a concern as staff did not have the required information they needed.

We looked at the administration and management of medicines because we found some concerns during our visit. We observed in two of the units nursing staff administered medicines to people and saw that they did not remain with the person to ensure they had taken their medication safely. This meant there was a risk that people did not take their medication as prescribed. We raised this with the senior manager who told us they would take immediate action and speak with the nursing staff. We did a sample check of the controlled drugs and found the records and storage to be correct. Other medicines were also stored correctly. We carried out checks of three people's medication records and found these had been completed appropriately. The provider had a medication policy and procedure, and staff received training and refresher training on the safe administration of medicines.

We looked at the cleanliness and infection control measures in place because we found some concerns during our visit. People we spoke with including relatives,

Requires Improvement

Is the service safe?

told us they found the overall cleanliness of the service and infection control measures to be good. Whilst we found the overall cleanliness of the service to be satisfactory, we found that there were concerns with the hygiene and cleanliness in the 'satellite' kitchen areas. These areas were used to serve food from and to make snacks and drinks. We found work surfaces stained, and fridges and microwaves dirty and unhygienic. There were no cleaning schedules for these areas and staff were not clear about who had responsibility for the cleaning of these areas. This meant there was a risk of cross contamination due to poor hygiene standards.

Domestic staff told us they had sufficient cleaning products and equipment to maintain cleanliness and showed us the cleaning schedules they completed on a daily basis. The provider had a policy and procedure on the prevention and control of infections. Staff told us they had completed training on infection control but were unclear who the nominated infection control lead was. Staff were knowledgeable about the procedures required for managing outbreaks of infections.

We observed staff practice safe moving and handling when supporting people. We also saw people had equipment such as pressure relieving mattresses that they had been assessed as requiring. Risk assessments in relation to people's assessed needs had been completed, this included assessments and reviews on people's dependency needs. We found risk assessments were reviewed on a regular basis. This showed the provider had assessed risks and had taken action to minimise any potential harm to people.

Staff had information available informing them of the action required to protect people from harm or abuse. Staff were aware of their role and responsibilities and we saw appropriate records had been completed and the action taken with regard to concerns of a safeguarding nature. Staff employed at the service had relevant pre-employment checks before they commenced work. This was to check on their suitability to work at the service.

Relatives told us they were involved in discussions and decisions about the care treatment provided. We saw the service had a policy and procedure on the Mental Capacity Act (MCA), and records confirmed staff had attended training on MCA. This legislation protects people who may not have capacity to consent to care and treatment. Staff demonstrated they had a best interest approach to care delivery. We found some examples that people's capacity to consent to care and treatment had been considered. However, the legislation states assessments and best interest decisions have to be decision specific. We found examples where decisions were generalised or the MCA had not been considered. We discussed this with the acting manager after our visit, who said they would review their systems and process to ensure they fully adhered to the MCA.

Deprivation of Liberty Safeguards (DoLS) is legislation that protects people from unlawful restriction of their liberty. On the day of our inspection there was a person who had an authorisation granted by the supervisory body to restrict them of their liberty. This showed the provider had taken the correct action to protect the person's safety and human rights. Staff were aware of how to protect this person.

Requires Improvement

Is the service effective?

Our findings

We found some concerns with records. This demonstrated a breach Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Some people required their food and fluid intake to be recorded due to their healthcare needs. We found records had not always fully recorded a person's intake as instructed in the plan of care. People that used the service including relatives, did not raise any concerns about people's hydration needs. We saw throughout the day people were offered and supported with drinks to maintain hydration. However, the lack of record keeping meant it was difficult to ascertain if people had received sufficient levels of intake for their assessed needs.

We found that some people had assessed needs and risks associated with their weight. Whilst the majority of people's weight was monitored monthly, we found from the records we looked at that a person had not been weighed for two months due to the hoist scales being out of order. No other alternative method to monitor the person's weight had been used. This was a concern as this person was known to of been losing weight, and should have had their weight closely monitored.

Some people had specific needs that required that they had a soft or pureed diet. Additionally some people had been assessed to need a fortified (high calorie) diet, and supplements to support safe eating and drinking. We saw supplements prescribed for people were available and food stocks met people's individual needs.

A person using the service described the food as, "Not too bad. If you don't like something they [staff] will do something else for you." A relative said, "[Name] is eating better since they've been admitted to the home." We spoke with the cook and looked at the menu choices. We saw there were systems in place that informed the kitchen staff of people's dietary and nutritional needs. People received a choice from two dishes however, people were required to make these choices the day before. This meant for people who had short term memory needs may have found this difficult.

We saw records that showed a person's decision about their end of life wishes had been discussed with the doctor, this document is referred as a 'DNAR'. Whilst the person had given their consent not to be resuscitated, we found there was a contradiction in the care plan records. These records stated the person had verbalised their wishes not to be resuscitated. However, the answer to 'Does the resident want resuscitating if they suffer cardiac arrest' the 'yes' answer had been circled. Whilst the DNAR would override any other information, records should be accurate to reduce confusion.

Staff spoke positively about the induction and training opportunities. A newly appointed care staff member said that they felt well supported in their role. We looked at the providers staff handbook and induction programme for new staff. This was comprehensive and based on the 'Skills for Care' a well-recognised training provider in health and social care. We saw staff received on-going training and support opportunities, this included meetings with their line manager, observational competency assessments on their practice and a yearly appraisal. This is a meeting to review staffs practice and performance. This enabled staff to understand, and develop the required knowledge, skills and experience of how to meet people's needs.

We found that people's needs had been assessed and care plans and risk assessments completed. These records informed staff what people's individual needs were and how they should be met. Systems were in place to monitor people's needs, this included a monthly review of care plans and risk assessments. We saw people received support to receive healthcare services for their general health such as opticians and chiropody, However, we found prompt action was not always taken in response to people's changing needs. For example, we looked at the daily notes and plan of care for a person who had needs associated with pressure ulcers. We found the plan of care did not clearly instruct staff on what the assessed needs were and the action required to provide care and treatment. We saw examples of delays to healthcare professionals such as dieticians and tissue viability nurses. This meant there was a risk to the person using the service as healthcare guidance had not been sought in a timely manner.

We observed a staff handover. This was a handover between care staff and nursing staff and between staff going off duty and staff starting duty. Information about people using the service was exchanged to enable all staff to be fully aware of people's needs. Staff showed they knew

Requires Improvement

Is the service effective?

the people they cared for well. This meant people could be assured staff were aware of their daily and on-going needs. This enabled consistency and continuity in the delivery of care and treatment.

Good

Is the service caring?

Our findings

People we spoke with told us they found staff to be 'caring and welcoming'. A person said, "Staff are courteous, when my door is closed they knock first." We observed that care staff were kind and caring but the majority of their time spent with people was 'task focussed', supporting people with personal care or daily living skills. Staff were seen to respect people's privacy and dignity. We saw staff used people's preferred name and knocked on people's bedroom doors before entering.

Staff used people's preferred names and spoke with people in a respectful and friendly manner. Appropriate light hearted banter was also used. Most people required support with eating and drinking. Staff were unhurried in their support. Some people were cared for in bed. Staff were organised and ensured people were comfortable and had their needs met.

We observed care staff provided care for people with high care needs. We found them to be caring and attentive to people's individual needs. This had a positive impact on people because they were supported to be comfortable. We observed care staff put the television on after lunch in one of the units. They did not consult the people present if they wanted the television on or give them a choice of what to watch. After a short while we saw a person get up and went to the television and showed their dislike to the television being on. This person was unable to verbally communicate their wishes but the care staff responded and turned the television off. Music was put on as an alternative which calmed the person. This behaviour may have been avoidable if the care staff had taken a different approach initially.

Relatives told us they were involved in discussions and decisions about the care and treatment provided and that their relatives were also involved as fully as possible. Comments included, "The staff are caring and whatever we ask we are given information we need." We saw records that showed there were regular discussions with relatives and representatives. This meant people who used the service and their relatives and representatives received opportunities to express their wishes and opinions about the care and treatment they received.

We saw there was information on display in the reception area including photographs of staff, the service, and useful information such as an independent advocacy service people could access.

Requires Improvement

Is the service responsive?

Our findings

Relatives said they were confident their relative's health and welfare needs were met, however they also told us it was sometimes difficult to find nursing staff to discuss their relative's health care needs. One relative said, "The staff are really good, they know just what to do, but information can be difficult to get as there's not always trained staff around to talk to." Another relative told us they were concerned that care staff got moved around the home and this affected the consistency of care provided.

A person who used the service told us they were aware of their care plans and that they had an understanding of them. They told us they had a shower once a week and that was their choice. A relative told us they had been involved in her relatives care plan. Comments included, "I've not looked at the plans of care in the recent past but if I say anything they [staff] jump to it." Another relative said, "Whatever we ask for we get a positive response and the information we need."

Information available for staff about people's preferences, routines, and social history was limited. We saw documents the service used to record this information had in the main not been completed. This was a concern as staff did not have detailed information that instructed them of what was important to people in the way they liked to be cared for. The acting manager told us after our inspection that they agreed that people's plans of care needed to be more personalised. They told us they had arranged a meeting with the nursing staff to discuss this. We saw records that confirmed what we were told.

We also found from the plans of care we looked at there were missing signatures, this meant it was difficult to ascertain if people and or their relative, had been involved in discussions and decisions about the care and treatment provided. We discussed this with the senior manager who showed us what action they had taken to resolve this issue. We saw a letter that had been sent to relatives that asked them to contact the service to arrange for plans of care to be discussed, and signed where their relative was unable to do this themselves.

People's religious and cultural needs were considered and the provider was responsive to people's needs and requests. Some people chose to show us their bedrooms, we saw these were personalised to their preferences and included items clearly important to the person. People had their photograph on their bedroom door, this helped those people who were confused and disorientated to maintain their sense of identity and find their way around. Staff told us there was active involvement by the local ministers and priests that visited the service. We saw details of these visits were displayed for people to be aware of visiting times. We saw the service had provided people with information about the provision of appropriate diets dependent on a person's religion and cultural needs. This included an acknowledgement of religious and cultural festivals. The service also stated that they would endeavour to employ a number of staff with a first or second language appropriate to the communication needs of people who used the service.

A relative told us they had asked for more than a year to have a patch of bare plaster painted in their mother's room and they were still waiting. This showed a lack of response by the service and was not respectful or considerate.

The provider had a complaints procedure that was available for people but some people had communication needs and may not have understood the information. We found from the recorded complaints we looked at that action had been taken in a timely manner and to a satisfactory resolution.

People using the service and relatives received opportunities to share their views and wishes about the service they received. We saw on display the feedback results from a survey completed by the provider in 2013. We also saw records that showed 'resident meetings' were arranged to enable people to share their views.

A person who used the service told us there were activities available but they chose not to participate, as they preferred to follow hobbies and interests on their own. We spoke with an activity co-ordinator. They showed us an activity timetable and records that demonstrated the activities people had participated in. We observed table top activities such as jigsaws, cards and dominoes were available. In one of the units picture cards were placed around for people to pick up. The activity co-coordinator told us this was to encourage conversation and engagement. On the day of our inspection the hairdresser was present. We saw how the activity co-ordinator supported people to visit the hairdresser. We also observed them in providing activities including hand massage, a card game and one to one conversations.

Requires Improvement

Is the service responsive?

We spoke with three care staff who said that whilst people received opportunities to participate in social activities, interests and hobbies this was limited. We observed one activity coordinator was on duty and we saw them in two of the four units actively engaged with people. We saw that when care staff did have the opportunity to spend time with people, not all care staff used this time effectively.

We observed parts of the home, particularly in the units for people living with dementia, had been enriched with items including sensory and tactile objects for people to hold and explore. These items provided an opportunity for reminiscence based exchanges between people who lived at the home and staff. However, most people in these areas had mobility needs and relied on staff to support them to use make use of the objects. We did not see during our visit that anyone independently or with support explored these areas. This was a missed opportunity for people to engage in pastimes hobbies, interests and memories.

We observed a staff handover. Information about people using the service was exchanged to enable all staff to be fully aware of people's needs. Staff showed they knew the people they cared for well. This meant people could be assured staff were aware of their daily and on-going needs. This enabled consistency and continuity in the delivery of care and treatment.

People had information available to them that promoted choice and people's rights. The senior manager showed us a document called 'My Bedside Booklet'. This had been developed to be kept in people's bedrooms and had information advising people about the service.

Requires Improvement

Is the service well-led?

Our findings

A relative told us they found the service to be 'variable'. Comments made by relatives included, "Like most roles, some people are good some not so. The last year's been a downward slope. Staff that were very on the ball have left." Other comments received from relatives included, "I think the home is organised, staff know what they're doing."

We received a mixed response from staff about their experience of the leadership of the service. Staff said they saw the acting manager during the day and a staff member described them as "hands on." Whilst some staff said the acting manager was supportive and approachable, other staff described them as, less approachable and that they did not always feel listened to.

The provider had a mission statement that informed people that used the service, visitors and staff about the culture and ethos of the home. This stated the provider had a personalised approach to care and an open and transparent culture. Whilst some staff demonstrated an understanding of the provider's vision and values, other's showed less awareness.

The provider showed a caring and supportive approach to its staff. The senior manager told us about the staff recognition award the provider had for all staff. They said that staff were recognised for their work and contribution and this was celebrated once a year with an evening of celebrations.

Staff told us they received opportunities to participate in staff meetings. We saw staff meeting records that demonstrated the acting manager was working to improve the service. For example, they had recognised that communication between nursing and care staff needed to be improved. As a response to this they had introduced changes to the 'handover' system in place. This showed that the acting manager had an awareness of the day to day culture, and the need to further support a more open and transparent culture to enable the service to develop.

We saw the service had regular audits in place that monitored the quality and safety of the service. However, the audit of care records had not always identified when action was required to improve outcomes for people. We saw records that demonstrated that the provider had systems in place to record accidents and incidents. We saw these were monitored and reviewed on a monthly basis for reoccurring themes, and how lessons could be learnt to reduce further incidents. We saw the acting manager had identified that information recorded required improvement. We saw a meeting with the qualified staff had been arranged to discuss this.

Staff we spoke with were clear about the process to follow if they had any concerns and knew about the whistleblowing policy, and that they would have no hesitation to use it if the need arose. Staff also showed that they had an understanding of their role and responsibilities.

Staff at the home worked with other organisations, we saw they had acted on feedback to improve practice. For example, the acting manager had implemented advice from the local infection prevention and control nurse. This showed the service had developed appropriate links with other organisations for information and support about best practice.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records **The registered person did not take proper steps to ensure people were protected against the risk of unsafe or inappropriate care and treatment. Accurate records for people were not maintained.**